		· · · · · · · · · · · · · · · · · · ·	
PLACE OF BIRTH		STATE BOAR	D OF HEALTH
District of	ORIGINAL CERT	FICATE OF BIRTH	سسيدر د
or But	(No Donvour	Sulch .	Local Registrar's No
FULL NAME OF CHILD	***************************************	 	Born YES
If child is not named, make Supple	mental Report on blank obt	ainable from local regist	rar. Alive
Sex of Child Male Triplet or other	\ and \ in order \ \ \ of birth	Legiti- Date of Birth	
Full FATHER Sunta	- 11 M	ull MOTHE aiden Many	Ingovich
Residence Orih	·R	esidence	an Birk
		Race mulica	Age at last Birthday (Years)
Birthplace Munuso	tu	irthplace Mich	eu
Occupation Labour	ō	ccupation	evol
Number of child of this mother	of children, of this mother, now living.	Were precautions taken as	rainst Ophthalmia neonatorum?
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*			
hereby certify that I attended the terminal with the there is no attending position or midwife, then the household make this return.	hysi-)	enature) & Z.	2 1914, at 0 A.M. Howeld m. Visician, midwife, bouseholder.*)
Given or christian name added f	rom a	Address Sc	ih
supplemental report	191 Filed 201/515	$\sim G$	Heledow LOCAL REGISTRAR
533-7020-47	28 Filed // // 6 18	1 Frue Copy	COUNTY REGISTRAR

the number of each, in order of blith, stated. This certificate must be filled by the attending Physician or Midwife with each local Registrar within 5 days after birth.